



ECI Provider Application for an Individual

A red arrow → indicates documents you are required to attach when submitting this application.

I. Demographics

Provider Name: _____
Last First Middle Initial

Address: _____
Street Address City State Zip Code

Phone#: _____ Date of Birth: _____ SS#: _____

Employed by: _____ Business Phone: _____ Fax: _____

Business Address: _____
Street Address City State Zip Code

II. Conflicts of Interest

Identify any relationships you have with any MHMRTC employee or Board of Trustees - Current MHMRTC Board Members are: William R. Brown, Lea Ann Capel, Roy Griffin, Linda Harmon, Elaine Klos, Carolyn Sims, Jim Teague, Theodis "T" Ware, and Lyn Willis. None If yes, indicate who below:

Person's Name Relationship to you

→ If any relationships, complete the Conflict of Interest Questionnaire (CIQ) located on MHMRTC's website: <http://www.mhmrtarrant.org/Your-Rights/Conflict-of-Interest> and attach it to this application.

III. Licenses for Service Delivery

License type: LPT OTR SLP Other: _____

→ Attach a copy of your discipline license

A valid Texas driver's license is required.

→ Attach a copy of your Texas driver's license

IV. Professional Experience & Skills

A. Tell us about your professional experience, emphasizing work with children under 3 years.



Attach a current resume.

B. Are you currently certified in Cardiopulmonary Resuscitation (CPR) for children and infants that included live demonstration, and covered first aid, and emergency care of seizures?



Yes *Attach a copy.* No *Register with MHMRTC's Training Dept. (no charge) or with another CPR training facility.*

C. Do you speak other languages besides English?

Spanish Vietnamese Other: _____
 Functional or Fluent

V. Health Status

A. A provider who routinely performs any job duty in proximity to any ECI child must provide evidence of negative TB testing.



Attach current TB test results.

B. Please disclose if you have any medical, physical and/or psychiatric issues (such as: substance abuse, medical marijuana, or needing special accommodations) that might affect your ability to perform the essential functions of your profession.



Document issues on a separate page.

VI. Provider Manual & Training

The ECI Provider Manual is a reference guide, designed as instruction to ensure quality services are delivered to ECI children and their families.

Read the Provider Manual <http://www.mhmrtarrant.org/Business-Opportunities/Provider-Relations> and attest that you understand its contents and that you have completed the required DARS/ECI training requirements, as described in the Provider Manual.



Sign the Attestation (page 6).

VII. Criminal History

Criminal background checks are conducted annually; details are available in the Provider Manual.



Complete the DPS Verification form (page 3).

VIII. DARS/ECI TKIDS

All professionals providing ECI services must be registered in the DARS/ECI TKIDS system to accurately document service delivery.



Complete the TKIDS form (page 4).

DPS Computerized Criminal History (CCH) Verification (AGENCY COPY)

I, _____, have been notified that a computerized criminal history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

APPLICANT or EMPLOYEE NAME (Please print)

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee of \$9.95 to the fingerprinting services company, L1Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

Signature of Applicant or Employee

Date

MHMR of Tarrant County /ECS
Agency Name (Please print)

Agency Representative Name (Please print)

Signature of Agency Representative

Date

Please: Check and Initial each Applicable Space	
CCH Report Printed:	
YES <input type="checkbox"/>	NO <input type="checkbox"/> _____initial
Purpose of CCH: _____	
Hire <input type="checkbox"/>	Not Hired <input type="checkbox"/> _____initial
Date Printed: _____	_____initial
Destroyed Date: _____	_____initial
Retain in your files	

CONTRACTOR INFORMATION AND UPDATE FORM For TKIDS

Name:						
(Last)		(First)		(Middle Initial)		
Race/Ethnicity: <i>(Circle Appropriate):</i>						
American Indian/Alaska Native		Asian/Pacific Islander		Black/African American		
Hispanic/Latino			White			
SS#: <i>(last 4 digits only)</i>		Start Date:		College Graduated From / Location:		
_____				Degree(s):		
				+ year(s) graduated:		
TKIDS CREDENTIALS						
<i>Please re-submit this section if your credentials change during your contract with ECI.</i>						
<input type="checkbox"/> BCBA						
<input type="checkbox"/> OT - Occupational Therapist						
<input type="checkbox"/> OTA - Occupational Therapy Assistant						
<input type="checkbox"/> PT - Physical Therapist						
<input type="checkbox"/> PTA - Physical Therapy Assistant						
<input type="checkbox"/> RN <input type="radio"/> Associates <input type="radio"/> Bachelors <input type="radio"/> Masters						
<input type="checkbox"/> SLP - Speech Language Pathologist						
<input type="checkbox"/> SLP - CFY						
<input type="checkbox"/> SLPA - Assistant in Speech Pathology						
<input type="checkbox"/> Other:						
State License # / Effective Date / Expiration Date:						
For SPLA, PTA, COTA						
Supervisor's Name & Credentials:						
PHONE #:			Have you worked at another ECI Program?			
			<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which program?			
HULEN STAFF COMPLETE THE FOLLOWING FOR CONTRACT STAFF						
Credentialing Application	Returned	To Credentialing	Approved	Contract Coversheet	Contract Log	
HULEN STAFF COMPLETE THE FOLLOWING AND ROUTE TO NEXT PERSON						
Enter into TKIDS [Deborah]		Entered in CMHC [Deborah]		Contractor ID #		
Staff Licensure Code Entered:	07 - LCSW 21 - LPT 51 - Other	08 - LBSW 23 - SLP 52 - EIS-EL	13 - LPC 29 - RN 53 - EIS-FQ	16 - LMSW 34 - LPC-I 60 - LPTA	17 - RD/LD 39 - Psych Assoc. 63 - COTA	19 - OTR/LOT 44 - Para Professional 65 - SLPA

IX. Checklist of Attachments

Indicate with a ✓ check mark to indicate items that you have attached.

Attached N/A

- Conflict of Interest Questionnaire, if applicable (Section II)
- Discipline License (Section III)
- Texas Driver's License (Section III)
- Resume (Section IV)
- CPR Card (Section IV)
- TB Test Results (Section V)
- Health Status, if applicable (Section V)
- Training: "Making It Work" certificates & self-assessment (Section VI & XI)
- Training: "Just Being Kids" videos - 6 observations & 6 progress notes (Section VI & XI)

X. Submission Instructions

Submit this application by U.S. mail, hand delivery, courier, fax, or email electronically to:

Laura Kender, Chief of ECS
ECI of North Central Texas RU3100
3880 Hulen Street, Suite #400
Fort Worth, TX 76107
817-569-5301
817-569-5348-fax
Laura.Kender@mhmrtc.org

False statements on this proposal by prospective providers may disqualify enrollment.

ECI reserves the right to reject any and all applications, to waive technicalities, and to accept any advantages deemed beneficial to the ECI program and its clients.

XI. Attestation

I do hereby attest that:

Indicate with a ✓ check mark.

Yes **No**

1. The information provided by me in and attached to this application is true and correct.
2. I have read and understand all elements of the **ECI Provider Manual** and agree to abide by its requirements, terms, and conditions, including instruction concerning: *(✓ each completed)*
- Parent Handbook**
 - Service Guidelines / Delivery**
 - Communicable Diseases / Notifiable Conditions**
 - Incident Reporting**
 - Home Visit Safety**
 - Dress Code**
 - Child Eligibility**
 - Service Descriptions**
 - Documentation & Timelines**
3. I have completed a Cardiopulmonary Resuscitation (**CPR**) that includes live demonstration, and covers **First Aid** and emergency care of **Seizures**.
4. I have read and understand the required **Training** section included and linked in the ECI Provider Manual: *(✓ each completed)*
- Infection Prevention**
 - Procedural Safeguards** (FERPA & HIPAA)
 - Client Rights, Abuse, and Neglect**
 - Making It Work (Sections 1 through 8)** - submit certificates
 - Self-Assessment** - submit assessment
 - “Just Being Kids” Videos** - complete an Observation form (available on the next 2 pages), as well as a Progress Note (on the last page) for **each** of the 6 videos and submit along with this application. This section will be a total of 18 pages.
 - Coaching**

By: Applicant: _____
Print Name

By Applicant: _____ Date: _____
Signature

→ Document each "Just Being Kids" video on this Intervention Progress Note form



early childhood services
MHMR TARRANT | WE CHANGE LIVES

ECI #: _____

Child's Name: _____

Medicaid #: _____

DOB: _____

INTERVENTION PROGRESS NOTE

Initial IFSP/Annual Review Date: _____		Orders Expire: _____	
Date: _____	Time Start: _____	Time Stop: _____	Code: _____
Service: <input type="checkbox"/> SST <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> Nursing <input type="checkbox"/> Family Ed. & Training			
Location: <input type="checkbox"/> HM <input type="checkbox"/> DC <input type="checkbox"/> Other <input type="checkbox"/> Interpretation/Translation <input type="checkbox"/> Joint Visit			
<input type="checkbox"/> Yes <input type="checkbox"/> No 28-day time line met for this service. If no, document reason on General Progress Note.			
Present at Visit:			
IFSP Outcomes Addressed		Addressed today:	
1. _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Developmental Goals supporting IFSP			
1. _____		Goal: Met <input type="checkbox"/> Cont <input type="checkbox"/> New Goal <input type="checkbox"/> Discont. <input type="checkbox"/>	
2. _____		Goal: Met <input type="checkbox"/> Cont <input type="checkbox"/> New Goal <input type="checkbox"/> Discont. <input type="checkbox"/>	
3. _____		Goal: Met <input type="checkbox"/> Cont <input type="checkbox"/> New Goal <input type="checkbox"/> Discont. <input type="checkbox"/>	
4. _____		Goal: Met <input type="checkbox"/> Cont <input type="checkbox"/> New Goal <input type="checkbox"/> Discont. <input type="checkbox"/>	
5. _____		Goal: Met <input type="checkbox"/> Cont <input type="checkbox"/> New Goal <input type="checkbox"/> Discont. <input type="checkbox"/>	
What has the family been practicing since last visit?			
What happened during the visit, who was involved, and how did the parent/caregiver participate?			
Measurement of progress towards goals during visit?			
Goal 1:	<input type="checkbox"/> Occurs Rarely	<input type="checkbox"/> Occurs Sometimes	<input type="checkbox"/> Occurs Often <input type="checkbox"/> N/A
Goal 2:	<input type="checkbox"/> Occurs Rarely	<input type="checkbox"/> Occurs Sometimes	<input type="checkbox"/> Occurs Often <input type="checkbox"/> N/A
Goal 3:	<input type="checkbox"/> Occurs Rarely	<input type="checkbox"/> Occurs Sometimes	<input type="checkbox"/> Occurs Often <input type="checkbox"/> N/A
Goal 4:	<input type="checkbox"/> Occurs Rarely	<input type="checkbox"/> Occurs Sometimes	<input type="checkbox"/> Occurs Often <input type="checkbox"/> N/A
Goal 5:	<input type="checkbox"/> Occurs Rarely	<input type="checkbox"/> Occurs Sometimes	<input type="checkbox"/> Occurs Often <input type="checkbox"/> N/A
What strategies does the family want to work on to achieve the goal(s)?			
Date / Time of next visit: _____ at _____ a.m. <input type="checkbox"/> / p.m. <input type="checkbox"/>			
Parent Signature: _____		Printed Name: _____	
Staff Signature: _____		Printed Name: _____	